Health Insurance: Employer Offerings and Employee Choice in State and Local Governments, 1992

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Summary 94-7

The parents of today's American workers were accustomed to being offered only one health plan by their employer, but today's employees can often choose between different plans and, in some instances, more than one type of health plan.

New data from the Bureau of Labor Statistics show that one-third of those State and local government units[1] that offered a health plan in 1992 offered more than one plan to their employees. Nearly seven-tenths of State and local government employees offered a health plan were offered more than one, and nearly six-tenths could choose from more than one type of plan.

In light of the national health care reform proposals being studied by policy makers, the issues of health care plan offerings and health care choice have assumed increased importance. At present, there are three leading types of health plans: Fee-for-service plans, health maintenance organizations (HMO's), and preferred provider organizations (PPO's). Each type of plan varies in terms of the restrictions placed on the choice of medical care providers. Fee-for-service plans generally reimburse a set percentage of the employee's health care costs, regardless of the health care provider chosen. HMO's offer prepaid care that must be obtained from a select group of providers. PPO's allow enrollees to choose their provider but offer financial incentives when designated doctors and hospitals are chosen.

This report provides information on the selections made by employees who were presented with a choice of various types of health plans. Since its inception in 1979, the Bureau's Employee Benefits Survey[2] has provided data on the percentage of workers who receive employer-provided health insurance through different types of funding arrangements. During this period, the percentage of employees covered by alternative plans, such as HMO's and PPO's, has grown significantly, and coverage under fee-for-service plans has declined.[3] Although the Employee Benefits Survey previously presented data on the percentage of employees participating in each type of health care plan, no attempt was made to identify the kind of plan chosen when more than one type of health plan was offered to the employee. These data are available for employees of State and local governments for the first time.[4]

Data from the 1992 survey of State and local governments show that nearly three-fifths of full-time employees with employer-provided health insurance participated in either an HMO or a PPO.[5] This represents a marked increase from the 1990 survey, which found that two-fifths of full-time employees participated in an HMO or a PPO. When given a choice, a significant proportion of employees enrolled in one of the two alternative plans. Among those employees offered a choice between a fee-for-service plan, an HMO, and a PPO, nearly four-fifths participated in one of the latter two alternative systems.

Funding arrangements

The growth of HMO and PPO enrollment has been one result of efforts to contain health care costs. Critics of fee-for-service plans contend that such plans provide little incentive to limit costs because of their practice of reimbursing enrollees for all usual, customary, and reasonable

[1] A government unit is defined as a unique location at which a State or local government agency conducts its operations. Therefore, it is possible that more than one location of the same agency may appear in the survey. For example, if two separate campuses of a State university system were sampled, each would represent a distinct government unit in the context of this study.

[2] The Employee Benefits Survey has provided information on the incidence and provisions of employer-provided benefit plans since 1979. The Survey includes details on paid leave, insurance, and retirement plans. Three different sectors of the economy are studied. Medium and large private establishments (100 or more employees) are studied in odd-numbered years. State and local governments and small private establishments (fewer than 100 employees) are studied in even-numbered years. Data in this report are from the 1992 survey of State and local governments.

[3] A study by A. Foster Higgins & Company, Inc., showed that average health care costs per employee in selected cities were significantly lower for HMO's than for fee-for-service plans. Similar, although not as striking differences were found when comparing average costs for PPO's with average costs for fee-for-service plans. For example, in Chicago, average costs for HMO's and PPO's were 27.3 percent and 13.2 percent lower, respectively, than average costs for fee-for-service plans. In the New York City metropolitan area, average HMO costs were 28.9 percent lower than average fee-for-service costs while average PPO costs were 20.2 percent lower than average fee-for-service costs. The average cost is defined as the sum of both employee and employer contributions to health coverage for employees, their dependents, and retirees. See A. Foster Higgins & Company, Inc., *Health Care Benefits Survey, 1992*, Princeton, NJ, A. Foster Higgins & Company, Inc., 1993.

[4] Similar data relating to employer offerings and employee choice in small private establishments in 1992 and medium and large establishment in 1993 are forthcoming.

[5] *Employee Benefits in State and Local Governments, 1992*, Bulletin 2444, Bureau of Labor Statistics, July 1994.

charges, regardless of who provides these services.[6] Critics also maintain that fee-for-service plans do not always take steps to ensure that there is a verifiable need for the care that is provided. In recent years, fee-for-service plans have taken steps to combat these criticisms by instituting numerous cost containment measures, such as preadmission certification and utilization review.[7] Both HMO's and PPO's take steps to encourage reductions in costs by emphasizing preventive medicine and by providing price reductions for care received from designated providers.[8]

HMO's provide comprehensive medical services to members on a prepaid basis. Typically, HMO's provide full coverage for inpatient care such as room and board, surgery, and medical consultations. Outpatient care, such as doctor's office visits and prescription drugs, may be subject to a copayment. The majority of HMO's require enrollees to receive all services from specific physicians and hospitals.

PPO's are another alternative to fee-for-service plans and, more recently, HMO's. PPO's contract with employer groups to provide coverage at discounted rates. Enrollees may then choose to receive care from either preferred providers or non-preferred providers. In either case, providers are reimbursed on a fee-for-service basis. If preferred hospitals or providers are used, however, enrollees are rewarded through lower deductibles, lower coinsurances, or increased limits on certain benefits.

Plan offerings

Virtually every government unit surveyed offered health insurance coverage, either fully or partially employer paid, to their employees in 1992. In turn, nearly all of the full-time employees represented in the survey were offered coverage.

The incidence of PPO and HMO plan offerings in State and local governments was significant. (See table 1.) However, fee-for-service plans, offered by seven-tenths of those units that provided coverage, were the most common. HMO's and PPO's were each offered by one-fourth of the government units surveyed.

Table 1. Health-care plans offered by type of plan, State and local government units, 1992

Type of plan[1]	By establishments	To employees
Total (percent)	100	100
With health care	99	100
FFS	69	62
PPO	25	46
HMO	25	59
Without health care	1	(1)

[1] Less than 0.5 percent.

NOTE: The sum of the individual items exceeds the total because establishments may offer more than one type of plan and employees may be offered more than one type of plan.

Table 2. Number of health plans offered, State and local government units, 1992

Number of plans offered	By establishments (percent)	To employees (percent)
Total	100	100
0	1	(1)
1	66	30
2	13	22
3	10	12
4	4	11
5	4	6
6	(1)	4
More than 6	1	14

[1] Less than 0.5 percent.

One-third of those government units that provided health care coverage offered more than one health plan to their full-time employees; one-fifth offered at least three plans. (See table 2.) In comparison, seven-tenths of all full-time employees in State and local governments were offered more than one health plan, and nearly one-seventh were allowed to choose from among seven or more options. This indicates that larger government units were more likely to offer more than one health plan to their employees than were smaller ones.

The majority of government units did not offer their employees a choice among different types of health plans. (See table 3.) When only one type of plan was offered, it was most likely a fee-for-service plan. One-fifth of the government units did, however, offer their employees a choice among types of health care providers. The most common choice was between a fee-for-service plan and an HMO, followed closely by the combination of PPO and HMO. Very few government units offered a choice among all three options. However, larger government units were more likely to offer more than one type of health plan, resulting in just

Table 3. Health plan combinations made available, State and local government units, 1992

Plans Offered	By establishments (percent)	To employees (percent)
Total	100	100
FFS Only	58	27
PPO Only	16	12
HMO Only	7	5
FFS and PPO	2	2
FFS and HMO	10	21
PPO and HMO	8	21
FFS, PPO, and HMO	1	12

NOTE: Because of rounding, sums of individual items may not equal totals.

[6] *Fundamentals of Employee Benefit Programs*, 4th ed. (Washington, DC Employee Benefits Research Institute, c. 1990), p. 209.

[7] In 1992, 84 percent of participants in fee-for-service plans in State and local governments were subject to some form of cost containment. See *Employee Benefits in State and Local Governments, 1992*, Bulletin 2444, Bureau of Labor Statistics, July 1994.

[8] The following discussion of HMO's and PPO's is taken largely from Thomas P. Burke and Rita S. Jain, "Trends in Employer-provided Health Care Benefits," *Monthly Labor Review*, February 1991, pp. 24-30.

Table 4. Health-care plans offered by type of plan and contributory status, State and local government units,1992

Health care provider	By establishment (percent)	To employees (percent)
All health care providers		
Employee coverage:		
Wholly employer financed	64	66
Partly employer financed	53	62
Family coverage:		
Wholly employer financed	27	36
Partly employer financed	80	85
Fee-for-service		
Employee coverage:		
Wholly employer financed	58	62
Partly employer financed	46	48
Family coverage:		
Wholly employer financed	28	38
Partly employer financed	75	69
Preferred Provider		
Employee coverage:		
Wholly employer financed	44	55
Partly employer financed	69	53
Family coverage:		
Wholly employer financed	12	25
Partly employer financed	90	77
Health Maintenance Organization		
Employee coverage:		
Wholly employer financed	72	60
Partly employer financed	62	63
Family coverage:		
Wholly employer financed	26	35
Partly employer financed	90	84

NOTE: The percentages add to greater than 100 because establishments could offer both a wholly employer financed and a partly employer financed plan, and therefore be included in both categories. Similarly, employees could be offered both a wholly employer financed plan and a partly employer financed plan.

over one-half of workers with health care coverage having a choice among types of health plans. In fact, nearly one-eighth of those government employees who were offered health care coverage could choose from among all three types of plans.[9]

Two-thirds of the government units paid the entire cost of the individual's monthly premium for at least one plan, while one-fourth did the same for family coverage. (See table 4.) Establishments were most likely to pick up the entire cost of individual coverage for HMO's, and were equally as likely to offer fee-for-service plans or HMO's at no cost for family coverage. PPO's were the least likely to be fully-paid by the employer.

Employee cost

Cost is a major factor in determining the appeal of health care plans, and it is difficult to gauge the effect of other variables, such as choice of providers, without first considering the cost factor. In an attempt to determine the effect of provider choice on enrollment, data for wholly employer-financed plans were studied. This eliminates the importance of monthly premium costs in the enrollment decision. Approximately one-seventh of full-time government employees were offered a choice of wholly employer financed health plans of different types. The most common combination offered was a choice between a PPO and an HMO. When such a combination was offered, there was a fairly even split in the type of plan chosen, with PPO's slightly more likely to be selected. The next most common combination was a fee-for-service plan together with an HMO. In this case, 3 employees selected a fee-for-service plan for every 2 who selected an HMO. Both of these findings seem to indicate that the freedom to choose a health care provider may take precedence over limiting out-of-pocket health care expenses.[10]

Table 5. Percent of medical care participants enrolled in health care plans, by combination of plans, State and local government units, 1992

Combination offered	Type of plan			
	Total	FFS	PPO	HMO
Total with a choice[1]	100	29	31	40
FFS and HMO	100	56	—	44
PPO and HMO	100	—	57	43
FFS, PPO, and HMO	100	22	44	34

[1] Includes other combinations not shown separately.

[9] It should be noted that there is a distinct difference between offering more than one plan and offering more than one type of plan. A single employer may offer three plans but all of these plans may be HMO's. In such an instance, this would be recorded as offering more than one plan but not as offering more than one type of plan.

[10] Out-of-pocket health care expenses are those charges that are paid by the enrollee rather than the insurer. In a fee-for-service plan, such expenses would include the deductible, coinsurance, and copayments. Out-of-pocket expenses are typically lower in HMO's, which usually do not subject enrollees to a lower deductible and coinsurance. For more information on differences in out-of-pocket expenses among plan types, see Allan P. Blostin, Robert B. Grant, and William J. Wiatrowski, "Employee payments for health care services,' *Monthly Labor Review*, November 1992, pp. 17-31.

Employee choice

As mentioned previously, over one-half of government employees were offered more than one type of health plan. (See table 3.) Most employees with a choice had an HMO as one of their options. The two most common choices were between a PPO or an HMO and a fee-for-service or an HMO. In addition, nearly one-eighth of full-time employees were allowed to choose from among all three plan types.

Among health care participants with a fee-for-service plan as one of their choices, 45 percent selected a fee-for-service plan. (See table 5.) Fifty-one percent of participants who were offered a combination of plan types that included a PPO chose a PPO and 42 percent of participants offered a combination including an HMO chose an HMO.

When offered a choice that included a fee-for-service plan, more employees selected them than chose HMO's or PPO's. For example, when a fee-for-service plan and a PPO were offered, 67 percent chose a fee-for-service plan. When faced with a choice between fee-for-service plans and HMO's, 56 percent chose a fee-for-service plan. Of those participants offered HMO's and PPO's in tandem, 57 percent selected a PPO, with the remainder choosing an HMO.

Finally, these data show a small, but significant, percentage of government workers did not participate in a health plan, even though they were offered at least one health plan. Specifically, 10 percent of full-time employees in State and local governments did not participate in a medical care plan, although 90 percent, an overwhelming majority, did.[11] Virtually all employees in State and local governments were, in fact, offered an employer-provided health plan. It is, therefore, possible that non-participating employees either could not afford the plan's premiums, had not yet completed service requirements necessary to participate, or had health care coverage provided through another source (for example, through a spouse's employer).[12]

Forthcoming data

These findings on health care offerings and employee choice in State and local governments represent the continuing efforts of the Employee Benefits Survey to develop new data that respond to user needs. Similar data for the Bureau's 1992 survey of small private establishments are currently scheduled for publication.[13] Similar data from the Bureau's 1993 survey of medium and large private establishments are also being readied for publication and will be presented in a forthcoming *Monthly Labor Review* article. Currently, a comparison of health care provisions is planned using findings from the most recent surveys of medium and large establishments and small private establishments in order to present estimates for the entire private sector. In the future, this data series will be published annually.

[11] *Employee Benefits in State and Local Governments, 1992.* Bulletin 2444, Bureau of Labor Statistics, July 1994.

[12] See the Technical Note for a discussion of the assumptions made in developing this data series.

[13] See Bucci and Grant, "Health Insurance: Employer Offerings and Employee Choice in Small Private Establishments," *Compensation and Working Conditions*, August 1994.

Technical Notes

Estimates from the Employee Benefits Survey are calculated from data on the benefits characteristics of employees in selected occupations, not the characteristics of establishments. Data are collected for a sample of occupations, which are selected with a probability proportionate to the size of each occupation's employment within each surveyed establishment. Every occupation within the surveyed establishment is not necessarily surveyed.

The availability of a certain benefit is then determined by whether or not the benefit is offered to the employees in these selected occupations. It is possible that the occupations selected may not have certain types of benefits offered to them while other, non-selected, occupations may be offered such benefits. However, the probability selection of occupations across a nationwide sample limits the effect of such an occurrence.[14] For more information, see appendix A in *Employee Benefits in State and Local Governments, 1992*, Bulletin 2444, Bureau of Labor Statistics, 1994. In addition, for this particular study, a key assumption was made concerning the data–namely, that all selected occupations in an establishment were offered a particular plan if at least one employee in a selected occupation participated in the plan. It could still be true, however, that certain groups of workers within selected occupations are not offered certain plans. For example, an establishment may offer two separate plans, an HMO for salaried employees only and a fee-for-service plan for hourly employees only. Under the above assumption, if the selected occupations included both the salaried and hourly employees, both would be shown as being offered a choice between a fee-for-service plan and an HMO.

To determine the effect of this assumption, the data were studied in two different ways. First, as described above, all occupations were assumed to be offered a plan if at least one employee in the establishment participated in the plan (assumption A). Next, any occupation that had no participants in a plan was assumed to have not been offered the plan (assumption B). Data were tabulated under each assumption and were then compared. Minor differences were present. As an example, the following are the findings under the above-mentioned assumptions for the percent of full-time employees in government units who were offered different types of plans:

	Assumption A	*Assumption B*
Fee-for-service	62	57
PPO	46	42
HMO	59	51

This example provides a representative look at the types of differences observed when comparing data under the two assumptions. First, although the estimates from the two assumptions vary, the trend remains the same. Under both assumptions, employees are most likely to be offered a fee-for-service plan, followed by an HMO and then a PPO. Second, fewer employees are offered plans when assumption B is used. This results in slightly lower estimates for data relating to plan offerings but has little or no effect on the percent of employees choosing to participate in a certain type of plan. This study uses assumption A throughout. This decision was made after evaluating the results obtained under both assumptions and conducting a detailed review of each surveyed establishment to determine the likelihood of improperly classifying the occupation.

It should also be noted that neither assumption has an effect on the establishment estimates. An establishment was counted as offering a plan whenever one existed, regardless of who participated in the plan.

A more complete description of the assumptions and statistical measures used to validate the reliability of the data will be included in the forthcoming report "Health Insurance: Employer Offerings and Employee Choice in the Private Sector."

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[14] In 1986, an internal analysis was conducted to assess the possibility of this situation occurring prior to the Employee Benefits Survey beginning data collection in the way described above. This analysis indicated that the situation, while possible, was remote enough that it would have only a negligible effect on the data.

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